MEDICAID/SCHIP DENTAL PROGRAM REPRESENTATIVES ASSOCIATION

RECOMMENDED RESEARCH PRIORITIES TO IMPROVE THE QUALITY, EFFECTIVENESS, AND EFFICIENCY OF MEDICARE, MEDICAID AND SCHIP PROGRAMS

June 30, 2004

Reimbursement and Utilization

1. What has been the impact of "marketplace" reimbursement on children's utilization of dental services in Medicaid/SCHIP? This would involve case studies of several states that have adopted marketplace dental reimbursement strategies to determine the impact over time on provider participation and dental utilization when rates first increased, then (in some cases) became stable, and then began to decline again in comparison to private sector reimbursement.

   Justification: Most research on reimbursement rates suggests that higher Medicaid dental reimbursement rates than most states currently offer will be needed to gain greater dentist participation. Anecdotal information from a few states also suggests that higher dental reimbursement rates are associated with higher levels of utilization. This study will help determine the relationship between reimbursement rates, dentist participation, and children's utilization of dental services in Medicaid/SCHIP. This research is a priority because many studies have found very low levels of dentist participation and children's dental utilization associated with current levels of reimbursement. Having a better understanding of the relationship between reimbursement rates, dentist participation and children's utilization of dental services will help states improve the effectiveness of their dental programs.

2. How does children's utilization of dental services vary in states that have both a traditional Medicaid dental program and a non-Medicaid SCHIP dental program, how do those utilization rates compare with those of children with private dental insurance and no dental insurance, and what factors are associated with differences in utilization?

   Justification: Some anecdotal evidence suggests that children's utilization of dental services is higher among those in SCHIP vs. those in Medicaid, in states that have both a traditional Medicaid dental program and a non-Medicaid SCHIP dental program. However, it is not clear whether the calculation of utilization rates is comparable for the two programs. This research is a priority because if utilization *is* found to be higher in SCHIP programs, it is important to states to determine the reasons why, which may have implications for the way in which traditional Medicaid programs are structured.

3. What are dentists' perceived non-reimbursement-related barriers to participation in children's Medicaid/SCHIP? This would involve a qualitative comparison of states that contract with: a) a single statewide (no-risk) dental program administrator; b) a single, or several (at risk) dental program administrators; c) states that administer their own

programs, (or that may have some elements contracted to a general administrative services organization).

Justification: Research on dentist participation in Medicaid/SCHIP programs has revealed a number of reasons why dentists don't participate in these programs, in addition to those associated with reimbursement rates, e.g., administrative hassles, broken appointments, lack of patient appreciation, delays in reimbursement, cumbersome paperwork, and prior authorization requirements. However, no studies have examined the extent to which the nature of the dental program administrative structure affects participation. This research is a priority because states have flexibility in how their Medicaid/SCHIP dental programs are administered, and, other factors being equal, may opt for a structure that is perceived as least onerous by dentists.

4. What has been the effect of dental caps in Medicaid/SCHIP programs on access and quality of care? Do dentists do "creaming," providing only covered services (or the most lucrative services), and leave the rest of beneficiaries' needs unmet? Or do dentists not participate in Medicaid/SCHIP programs to avoid feeling forced to practice that way? What is the impact on beneficiaries of having to pay the balance out-of-pocket?

   Justification: A few states have imposed dollar caps on the amount of dental care they will reimburse for over a given time period. The effects of these caps on beneficiaries' access to care, out-of-pocket expenditures, and quality of care are unknown. This research is a priority because many states are under financial pressure to reduce their Medicaid/SCHIP expenditures, and dental services are often the first to be cut or reduced because of the perception by many policy makers that they are discretionary services. Knowing the effect of caps will help states make more evidence-based decisions about whether to impose them.

5. What has been the effect of cutting adult Medicaid dental services on *children's* use of dental services?

   Justification: There are several studies in the medical literature, and a couple of unpublished reports in the dental literature, that suggest that Medicaid children whose parents lack medical or dental coverage are themselves less likely to use dental services. This research is a priority because many states have cut or reduced adult dental benefits without considering the impact on children's use of services. Knowing the impact on children will help states make more informed decisions on cutting adult dental services.

6. What are the differences in access, quality of care, costs, and retention of children between Medicaid/SCHIP dental programs that use a dental managed care delivery system model vs. those that use the traditional fee-for-service model, and what have been the impacts in states that have switched from one delivery system to the other?

   Justification: Many Medicaid/SCHIP medical programs use a managed care model. Far fewer use dental managed care, and some states have tried dental managed care and returned to a fee-for-service model. There have been no published studies regarding

differences in access, quality of care, costs or retention of children between Medicaid/SCHIP dental programs using these two models. This research is a priority because states are under increasing pressure to control the costs of their Medicaid/SCHIP programs, and managed care offers the ability to help do that. Knowing the answers to these research questions will help states make more informed decisions about the advantages and disadvantages of these two delivery systems.

7. What is the extent of dental vs. medical uninsurance and underinsurance among children and adults at the state and national levels (including the extent to which those with medical coverage lack dental coverage)?

   Justification: Virtually all discussions of "health" insurance, and the lack of it, are really references to *medical* insurance. Relatively little is known about the extent to which children and adults are dentally uninsured or underinsured, yet it is well known that persons without insurance (both medical and dental) are less likely to use medical and dental services. One thing that is known is that for every person without medical insurance, there are approximately 2.5 persons without dental insurance. This research is a priority because state-level dental insurance data are largely unavailable, and policy makers need such data to make informed decisions about the need for publicly funded dental insurance, including offering "wraparound" dental coverage for children with medical coverage who are otherwise eligible for SCHIP.

8. What is the effect of case management on utilization and costs of dental services in Medicaid/SCHIP?

   Justification: Case management is a common practice used by medical plans, but very uncommonly used by dental plans. Hawaii recently began a case management program in its Medicaid dental program that anecdotally has resulted in increased utilization of dental services. However, little is known about the cost-effectiveness of this approach or the extent to which it is being used by other states. This research will help determine whether dental case management is a practical approach for Medicaid/SCHIP programs to implement. This research is a priority because of children's low use of dental services in Medicaid/SCHIP and the potential of a case management approach to increase it.

Health Outcomes

9. What has been the impact of states reducing or cutting Medicaid adult dental services on the overall health of those adults, their use of Medicaid and Medicare *medical* services, and on Medicaid and Medicare medical costs, including the costs of hospitalization, emergency room use, and treatment of conditions associated with poor oral health? A corollary research question is to what extent does spending on preventive and restorative dental care for adults save money in acute medical and dental care costs?

   Justification: Poor oral health has been associated with a number of medical conditions, including adverse birth outcomes (preterm and low birth weight babies), diabetes, cardiovascular disease, stroke, and respiratory problems. Consequently, the reduction or

elimination of Medicaid dental services for adults may result in the unintended consequences of adverse medical conditions and unforeseen medical expenditures. This research is considered a priority because 1) it has the potential to demonstrate that oral disease management in adults is more cost-effective than reducing or eliminating dental benefits, and 2) it has crosscutting implications for the Medicaid and Medicare programs (e.g., treatment of periodontal disease in a Medicaid adult by a dentist may affect Medicare-financed disease management of diabetes in that individual).

Enrollment

10. What factors influence Medicaid/SCHIP beneficiaries to initially enroll and subsequently maintain their enrollment in Medicaid/SCHIP?

    Justification: Anecdotal evidence suggests that a number of children who are initially enrolled in but subsequently lose their eligibility for SCHIP, are eligible for Medicaid, yet do not enroll. Some reasons that have been offered include the stigma associated with Medicaid programs and fear that enrollment in Medicaid will jeopardize immigration status. Other evidence suggests that the availability of dental coverage offered by SCHIP is what attracts many families to enroll. This research is a priority because better knowledge about the factors that drive enrollment in Medicaid/SCHIP will help states make more informed decisions about how to market these programs in such a way as to maximize children's enrollment.

11. How long do Medicaid/SCHIP beneficiaries stay enrolled in these programs, and what is the impact of their length of time in the program on costs and utilization?

    Justification: Little is known about how long Medicaid/SCHIP beneficiaries stay enrolled in these programs, yet length and continuity of enrollment have important implications for their ability to access the dental services they need, as well as on program costs. States also vary in terms of how often they require reapplication and recertification, and these, too, affect access and costs. This research will help states determine the effects of length of time in these programs on program costs and utilization. This research is a priority because knowledge about the effects of length of time in Medicaid/SCHIP on program costs and utilization will help states make more informed decisions about their enrollment policies.